Preeclampsia Services – Prescription for Home Administration

Fax signed form to: **866-252-4293** or **866-731-9011** OR scan signed form to OBHIntake@optum.com

NOTE: Copy of current **INSURANCE CARD (front & back)** must accompany submission. Initiate & manage homecare **per Optum Protocols** as provided for following services OR call Optum @ **800-950-3963** for other orders.

Form Completed by (Name, Title, Phone): _____

Patient Name:			Phone:
Address:		City/St./Zip:	
DOB:	Due Date:	Height:	Weight:
Preferred Language: ☐ English ☐ Other		Allergies:	
Pt. Current Location: ☐ Home ☐ Hospital (name)			Patient Arm Circumference: (If known, in CM)
Insurance Info: (Carrier, Policy #, Phone #)			

Service Requested

Service start will occur upon verification, patient acceptance, and receipt of medical devices.

☐ **At Risk for Preeclampsia and Early Gestation Hypertension Surveillance**

- For patients ≥ 20 weeks gestation at risk for developing preeclampsia.
- For patients < 20 weeks gestation requiring blood pressure (BP) surveillance.

BP Threshold Order (check one) ☐ 140/90 ☐ 150/100 ☐ 160/110

☐ **Add Postpartum Preeclampsia Surveillance (30 day)**

**Provider will be notified when patient meets full preeclampsia criteria

Criteria (check all that apply)

☐ History of preeclampsia
☐ Gestation hypertension
☐ Chronic hypertension
☐ Other combined risk factors

_____

Increase in BP may not be present

☐ **Preeclampsia Surveillance with postpartum follow-up (30 day)**

- For patients ≥ 20 weeks gestation diagnosed with preeclampsia, characterized by more than 1 occurrence of BP ≥ 140 and/or 90 and proteinuria.
- For patients ≥ 20 weeks gestation meeting BP criteria for preeclampsia and have preexisting chronic proteinuria.

We do not accept patients with severe features

BP Threshold Order (check one)

☐ 150/100
☐ 160/110

☐ **Postpartum Preeclampsia Surveillance (30 day)**

- For patients *not currently* on Optum services diagnosed with preeclampsia at delivery.
- For patients *not currently* on Optum services and at risk for postpartum preeclampsia.

BP Threshold Order (check one)

☐ 140/90
☐ 150/100
☐ 160/110

Initial Prescriber (Signature Required)

I certify that this patient is under my care and that the above services are medically necessary and are authorized by me with the above written plan of treatment. My signature acknowledges that (i) I have received and reviewed the protocol that accompanies this plan of treatment and understand and accept responsibility for the patient's care, and (ii) my state medical license is current and valid as indicated below. ***Please provide email for Plan of Care receipt/signature***

Prescriber Signature: _____ Print Name:_____

NPI#:_____ License #:_____ State:_____ Date:_____

Practice Name:		Office Contact:
Address:		City/St./Zip:
Phone:	Fax:	Email:

If ongoing care of this patient will be managed by another provider, complete the information below. As the prescriber, you are responsible for full care of this patient unless/until ongoing managing provider's prescription is received by Optum. At that time, all care responsibilities for this patient will be transferred to the alternate provider and the initial patient care prescription is discontinued. ☐ **Provide status reports to both OBGYN & MFM**

Provider's Name: _____ Phone: _____ Fax:_____

FOR INTERNAL USE ONLY	Telephone Order From:		
	RBV by Optum Nurse:	Date:	Time:
	RX Reviewed by Optum Nurse:		Date: